Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NORTHWEST TEXAS HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-3450-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges incurred in the course of the Claimant's treatment totaled $38,351.00. At the time, hospital staff was advised by [employer] that it had not yet reported the injury to its workers compensation carrier. The employer asked to receive the hospital's bill indicating that they would send it to the workers compensation carrier along with the report of injury…Applicable mailing records indicate that it was received by Carrier on the date of 10/27/11."

Amount in Dispute: $8,724.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Yet Texas Mutual on 4/8/15 only first received the bill from NORTHWEST TEXAS HEALTHCARE SYSTEM."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2014 through August 16, 2014	Inpatient Hospital Services	$8,724.43	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective June 1, 2012 sets out the procedures for resolving a medical fee dispute.
3. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - CAC-29-The time limit for filing has expired.
   - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 731-Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.

- 895-133.210 requires itemized statement for hospital services.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891-No additional payment after reconsideration.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "CAC-29."

Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

The respondent states "Texas Mutual on 4/8/15 only first received the bill from NORTHWEST TEXAS HEALTHCARE SYSTEM."

The requestor submitted a copy of the letter requesting reconsideration that states "The Claimant presented at and was treated by the NORTHWEST TX HOSPITAL on the date of 08/12/2015. At that time, hospital staff obtained information concerning this as a worker's comp injury. The charges were billed to Texas Mutual on or about the date 04/08/2015 and were subsequently denied payment on 05/04/2015."

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent.

The Division finds that the requestor did not submit any documentation to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/29/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.